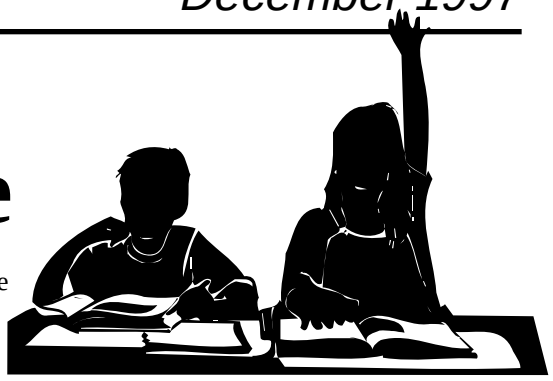
Vermont EMS Today

December 1997



From the Director

Learning from a Rookie

Recently a new squad member joined my night crew on the ambulance service I work with. It's always fun to be involved with new people just starting out in EMS. New members remind me that there are still plenty of good folks out there willing to serve others. They inevitably have a certain energy and zeal that has long since been dampened in me by a dose of reality.

When I think back about my own career in EMS, it is as much the people who were my early role models as those who were my formal instructors that shaped the EMT I have become. That "mentoring" relationship is something that I have come to see as very important in the development of good emergency responders.

One of the early calls I ran with our new member was for an elderly woman who was intoxicated and had fallen. As we rolled out the door, I remember thinking facetiously something to the effect of: "Gee, this sounds like a real serious emergency." When we arrived on the scene, a police officer stepped out of the residence and told us that the patient had a significant head laceration and there was lots of blood around. From the driveway I could see blood on the walls, the door and the floor. Perhaps this call was going to be more interesting than I had initially imagined.

We assessed the patient and found an impressive contusion/laceration on the back of her head, which she was oblivious to. A little blood goes a long way, but this living room had been painted red. With so much blood spread around, I could not tell where and how the injury had occurred. There was a strong odor of ETOH about the patient and a half-empty bottle of vodka on the kitchen counter. I couldn't recall transporting this person before, but she was a known figure to both the police and my driver. The patient's adult daughter was at the scene and her behavior led me to believe that she too was a veteran of many past similar experiences with Mom.

My intent was to make sure she understood the assessment and care we had provided.

We did the usual and expected care of controlling the bleeding and administering oxygen. The patient was ambulatory and complained of no neck or back pain. Given the size and position of her contusion, we opted to transport her sitting up. The trip to the hospital was uneventful and the ED staff agreed that the patient's injury was more imposing than a radio description could do justice to. We filled out the paperwork, cleaned up the rig and went home.

Back at the station I sat down with our new member and asked her what she thought about the call. My intent was to make sure she understood the assessment and care we had provided. She took a

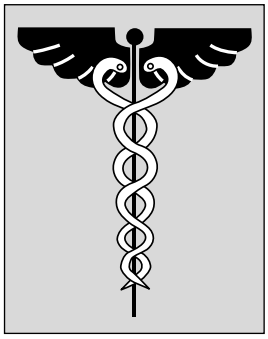
CONTINUED ON PAGE 3

Inside:

From The Medical Advisor

Screening: By What Standard?

A recent spate of responses have caused a number of providers to ask, what criteria ought we to use to allow personnel back into hazardous environments such as fire scenes and haz-mat situations? The response from this office is a simple one: that is beyond the scope of practice of our certified providers.



As anyone who is certified to provide prehospital care in this state knows, there is nothing in any of the national standard curricula, which we in Vermont use, about how to judge whether someone on an emergency scene can re-enter service in a high intensity, high risk environment. And of course, nowhere do we find an ability to do "medical monitoring" of personnel, especially hazardous materials response teams.

Vermont certified EMS personnel frequently respond with other agencies, local or state, to "stand by" in case someone becomes ill or injured at these risky scenes. Clearly, there is no reason to stop this support of our colleagues in other arms of public safety. If your sponsoring agency has developed appropriate training and policy in conjunction with medical direction, it may be okay to obtain vital signs for use by the other agencies under their own set of guidelines and policy. Mind you, I do not recommend doing that because the exposure of not communicating the information gathered in a timely fashion or commenting on clearly abnormal vital signs or symptoms is enormous. It must be understood, however, that Vermont certified EMS providers are not making any determination about fitness or stability in these instances. Medical direction is not in place for this activity and is not supported.

Vermont certified EMS personnel frequently respond with other agencies local or state, to "stand by" in case someone becomes ill or injured at these risky scenes.

Each of us realizes that a good fire safety officer will have required good medical physical exams by qualified physicians, will have ongoing yearly updates of these, will have obtained baseline vital signs and weight and will have in place a standard set of criteria to judge fitness on the scene. When we step in to assist, it is presumed (boy, is that dangerous!) that we have this same understanding and basis. It will be presumed that we have some basis to say that a person is fit to begin or resume work and is fit to do so under an understanding of what constitutes abnormal vital signs, weight and physiology. Fire safety officers will conclude that if we can determine vital signs and some symptoms have not resolved or returned to baseline in some timely fashion, that the personnel should not begin or continue work. By the way, I would have difficulty today giving precise guidance in any of those areas myself.

Our desire to be helpful, built upon the obvious fact that today we do things of a medical nature, has sometimes led to the mistaken belief that Vermont certified prehospital providers have the ability to make determinations that personnel are safe to begin or continue work that is frequently high energy and high stress. We know that we would never presume to tell our neighbor that they were fit to begin a new health club exercise routine. We would not presume to do a "screening medical exam" for our own children entering camp. We need to understand that others might easily assume that our participation in mandated screening means that we have the expertise and training to allow "screening" of other professionals as we join together at local scenes. The liability is huge and our rightful foundation upon which to do this work, is nonexistent.

When called upon to join others in public safety in answering the needs of the public we serve, we should be willing and participatory at any level that is within our scope of practice and training. If we do more than that, we breach the public trust, offer a service that is likely below standards, and place people's lives at risk.

—Wayne J.A. Misselbeck, M.D.
Medical Advisor

Vermont EMS Today
is published quarterly as a service for Vermont's emergency medical providers. Suggestions, comments and news items are always welcome. Write or call Leo J. Grenon, Vermont Dept. of Health, 108 Cherry Street, Box 70, Burlington, VT 05402. (802) 863-7310 or 1-800-244-0911 (in Vermont only). Email: VTEMS@VDH.STATE.VT.US

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the facts: thought you would like to know

Impaired Pedestrians

Background

While the dangers relating to drinking and driving are well-documented, there is another deadly alcohol-related problem that receives far less attention—impaired pedestrians. In 1995, alcohol involvement—either for the driver or the pedestrian —was reported in nearly 50 percent of the traffic crashes that resulted in pedestrian fatalities. In the past, we have encouraged individuals not to drive after drinking, but have failed to send the message that impaired walking is also dangerous and can result in injury or death.

Impaired pedestrian activities are a perfect fit with 3D Prevention Month activities. Almost all pedestrian fatalities involve a motor vehicle. Drivers need to be on the lookout for pedestrians who may have had too much to drink. When impaired by alcohol, pedestrians typically make critical errors that result in a crash. However, if drivers are more cognizant of impaired pedestrians, they may be able to avoid crashes through evasive actions. Drivers need to be educated on impaired pedestrian issues so they are more aware of their roles in preventing these crashes.

Impaired Pedestrian Characteristics

Research has shown that pedestrian crash victims often have very high blood alcohol concentrations (BAC), indicating binge drinking and/or severe chronic drinking. About 25 percent of fatally injured pedestrians have a BAC greater than .20. Often times, individuals are making "purposeful trips," i.e., going to the store for cigarettes, food, or more alcohol.

Crash Data

Of the pedestrian fatalities in 1995, 31 percent had BAC levels in excess of .10. The intoxication rate for drivers was less than that — 14 percent. Over 20 percent of fatal pedestrian crashes involved a pedestrian who was intoxicated and a driver who had not been drinking.

The highest rate of intoxication for pedestrians killed in traffic crashes was reported for pedestrians 25 to 34 years old. These pedestrians are also more likely to be males.

Alcohol involved pedestrian fatalities are more likely to occur within urban areas. In rural areas, roadways with a posted speed limit of 55 miles per hour (mph) or higher are the sites of most intoxicated pedestrian fatalities; in urban areas the sites are roadways with posted speed limits of 40 to 50 mph and 30 to 35 mph.

Prevention strategies

Prevention strategies designed to reduce alcohol-impaired driving may be adapted to reduce intoxication among pedestrians. Examples include laws that control the availability of alcohol; early identification and treatment of persons with alcohol problems; and training law enforcement officers and point of sale personnel about impaired pedestrian dangers. Additional strategies include using environmental approaches (improved lighting, speed control measures on commercial strips); initiating public awareness and education campaigns to inform pedestrians and alert drivers about the hazards associated with walking while impaired; and devising different interventions for use on high-speed roads in rural areas and medium-speed roads in urban areas.

This information was supplied to us from the Governor's Highway Safety Program.

From the Director
Learning from a Rookie

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somewhat different tack by saying how sad she felt that this patient and her family's lives were being destroyed by alcohol. She talked about the effects that alcohol had within her own family and some of the problems she had seen firsthand. She wanted to know what else we in EMS could be doing about this type of situation. I found myself a bit uncomfortable, not having very good answers to some of the questions she was asking. It surprised me how clearly she had focused on the root of the problem rather than getting caught up in the "band-aid" that we sometimes put on the problem.

I suspect that most people who are in EMS for a long period of time get a little hardened to the effects that alcohol has on our work. Let's face it, without alcohol, the demand for EMS would be significantly reduced. Sometimes we joke about it with little ditties like; "If it's a Friday night car crash and you don't find somebody drunk, keep looking because you haven't found all the patients." Perhaps some of us aren't as responsible about our own alcohol consumption as we might wish others to be. Probably most of us aren't involved in trying to prevent the devastating health effects of alcohol abuse that we routinely see.

My conversation with this rookie reminded me how easy it is to lose sight of the tangible human costs associated with the work we do. We do provide an important service to people at a time in their lives when EMS may be the only safety net available. EMS does have a role in prevention and in long term social change. While few of the emergencies we respond to are crises for us, they frequently are to our patients and their families. The conversation also reminded me that there is a lot to learn from everyone we encounter in the EMS system. It pays to keep an open mind and be willing to consider a perspective that may come from an unexpected source.

Best wishes to all for a safe and peaceful holiday season!

— Dan Manz, Director

In Recognition of the 10th Year of EMS Award Winners

It seems just a short time ago when the first awards ceremony was held at our original Vermont EMS Conference in 1989 in Rutland. Since that time, more than 63 of Vermont's EMS providers have been recognized for their outstanding contributions to EMS. Over the past decade, we have been fortunate to receive numerous nomination letters for our awards program. Each year however, noteworthy EMS providers within Vermont go unrecognized because members of the EMS community never get their letters in. Many of us feel compelled to nominate an individual, but when it comes to putting pen to paper we fall short of completing the task. The following is a list of suggestions that can provide guidance in writing nomination letters.

★ Consider the correct awards criteria for the individual you're interested in nominating.

★ Remember, awards are based on an individual's or service's overall contribution to the field of EMS. Avoid focusing on single acts of heroism.

★ Make sure to completely identify the individual or service at some point in the letter and the exact award you wish them to be nominated for. Frequently we will receive letters that do not specify the award category.

★ Make a simple outline of your thoughts. Jumbled information is confusing and often clouds the characterizations that recognize outstanding members.

★ When you write your letter, keep in mind that it will be read by several committee members who may have no familiarity with the person or service.

★ And finally, have someone proofread your work.

One quality nomination letter is of greater significance then several poorly crafted ones. Leave yourself enough time to write a nomination that is easily read and thorough in describing the accomplishments of your nominee. It is a rare occasion that we take the time to recognize accomplishments in EMS; take the time to let us know.

EMS Awards Information

The annual Vermont EMS awards are a public opportunity to recognize our state's finest EMS professionals. In many ways, these are the "people's choice" awards. Nominations come from colleagues, friends, other public safety agencies, municipal officials and grateful patients. Selection of the award recipients is done by committees of peers, including the 1997 award winners. Nominations for this year's 1998 Awards program must be received by Friday, February 13, 1998. Mail them to: Vermont Department of Health, Emergency Medical Services, P.O. Box 70, 108 Cherry Street, Burlington, VT 05402, attn: Rob Schell.

CRITERIA FOR EMS AWARDS

BASIC RESCUER OF THE YEAR

1) Is currently certified ECA or Vermont Basic EMT.
2) Has made an exceptional contribution to his/her EMS service.
3) Has strong and consistent clinical skills at his/her certification level.
4) Has made an outstanding contribution to the EMS system either within or outside his/her squad or service.

ADVANCED RESCUER OF THE YEAR

1) Is currently certified Vermont Advanced EMT at any level.
2) Has made an exceptional contribution to his/her EMS service.
3) Has strong and consistent clinical skills at his/her certification level.
4) Has made an outstanding contribution to the EMS system either within or outside his/her squad or service.

EMS SERVICE OF THE YEAR

1) Is a currently licensed ambulance or first responder service based in Vermont. (Licensure level is not to be considered.)
2) The service has made an outstanding contribution in the past year to public education.
3) The service maintains positive, outstanding relations with the communities it serves and the local EMS District Board.
4) The service takes visible and meaningful steps to assure the professionalism of personnel and quality of patient care.

EMERGENCY NURSE OF THE YEAR

1) Is currently licensed nurse at any level working in a Vermont hospital emergency department.
2) Has made an exceptional contribution to his/her hospital.
3) Has made an outstanding contribution to the EMS system either in conjunction with hospital duties or outside the scope of regular work.

EMERGENCY PHYSICIAN OF THE YEAR

1) Is currently licensed physician working in a Vermont hospital emergency department or a critical care specialist who regularly receives patients in an emergency department.
2) Has made an exceptional contribution to his/her hospital.
3) Has made an outstanding contribution to the EMS system either in conjunction with hospital duties or outside the scope of regular work.

OFFICER OF THE YEAR

1) Is an officer as determined by the Vermont licensed ambulance or first responder service the person is affiliated with.
2) Has demonstrated positive leadership for the service, resulting in a stronger organization.
3) Has represented his/her service in a positive manner to other groups and organizations within the EMS system.

EMS TRAINER OF THE YEAR

1) Is a training officer of a Vermont licensed ambulance or first responder service or an EMS District Training Coordinator or an EMS District recognized course instructor/coordinator.
2) Has made a recognized contribution to the EMS system through outstanding organization or delivery of training.

VERMONT SAFE KIDS INJURY PREVENTION AWARD

1) Is currently affiliated with an emergency medical services district or a licensed ambulance or first responder service in Vermont.
2) Has made an exceptional contribution to his/her organization in the area of injury prevention or public education.
3) Has made an exceptional contribution to the promotion of injury prevention and public education in emergency medical services.
4) Has made an exceptional contribution to his/her community in the area of injury prevention or public education.

VERMONT AMBULANCE ASSOCIATION EDUCATION SCHOLARSHIP AWARD

The Vermont Ambulance Association is pleased to offer a scholarship in the amount of $500. It is available to any member in good standing of a licensed VT EMS organization. This is to further their education in the provision or management of health care. Recipients will be chosen by the VAA. Submit nominations or applications to the VT EMS office. ■

— Robert W. Schell

Toll-Free Number

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1-800-244-0911

EMS Fax Number **1-802-863-7577**

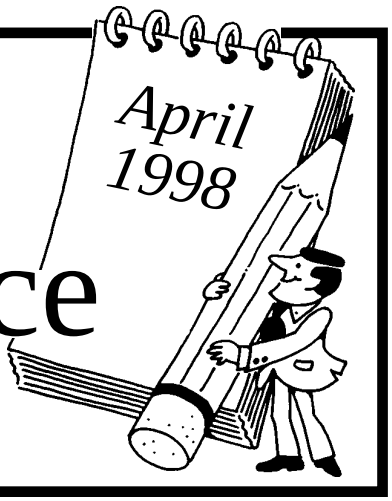
Email **VTEMS@VDH.STATE.VT.US**

MARK YOUR CALENDAR!

1998 EMS

Conference

APRIL 3, 4, & 5, 1998



SPECIAL PROJECT UDATE

EMSC Partnership Grant

The Vermont Department of Health will continue to improve the capacity of the emergency service system to manage pediatric emergencies for the next three years with the assistance of the Maternal & Child Health Bureau's Partnership Grant. The focus of this grant is to provide personnel to continue several ongoing projects, including injury prevention, resource management and training. The grant includes funding for a quality assurance project and start up costs to begin delivery of the Basic Trauma Life Support-Pediatric program.

Pediatric Office Resuscitation Project

From Newport to Concord to Bennington, the team of Barry Heath, M.D., Jean Coffey, R.N., and Patrick Malone have visited nearly 30 pediatric and family practice offices as part of the Pediatric Office Resuscitation Project. Local EMS services have been well represented at sites around the state.

The Pediatric Office Resuscitation Project has raised a number of issues regarding EMS response to medical facilities. To our surprise, many health care professionals and office staff did not know how the EMS system functions. Many were aware of how to access the system, but they had no idea what type of response would arrive. They did not know the difference between first responders and ambulance crews. They did not realize the different levels of care available. The concept of medical direction, and how the prehospital personnel function, was unknown.

Several operational issues were also brought up. Among the many suggestions provided to the people in the field were the following:

Develop an emergency plan. The plan should include who will activate the EMS system, provide directions to the service, meet the ambulance and decide which entrance would be the easiest to use.

Develop a working relationship between the local prehospital organization and the doctor's office. It is much better to get to know each other prior to the emergency. Knowing each other's capabilities and limitations is essential.

Participate in joint training. The training could be scenario based, so that everyone benefits. The pediatrician could assist the EMS agency with pediatric specific squad training, and the service could provide emergency care training to the office staff.

Provide feedback on specific patients. If there is an emergency, providing quality assurance to ensure future performance or to identify areas of improvement would be helpful to all parties involved.

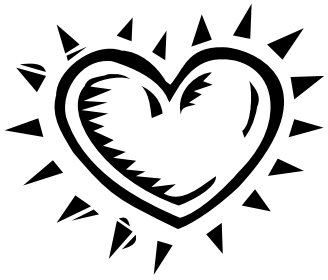
The Pediatric Office Resuscitation Project has identified these issues in terms of the pediatric population. Many of the lessons learned can be applied to all physicians' offices and clinics.

Project Heart Start

For the past several years, the Vermont affiliate of the American Heart Association, in conjunction with Fletcher Allen Health Care, Sheraton Burlington and several other organizations, has sponsored Project Heart Start. In the past this one-day event has targeted the general public for a mass training in the American Heart Association's Heartsaver program. The Heartsaver program focuses on the prevention of cardiovascular disease and adult CPR.

This year the focus has changed to children, with the delivery of the Pediatric Heart Start Program. This one-day program will focus on childhood injury prevention and infant/child CPR. The Vermont EMSC Project is participating in this program with a donation of learning materials and staff support. For more information call the American Heart Association at 1-800-639-6024 or visit their web site http://www.angelfire.com/vt/heartstart

— Patrick T. Malone



Congratulations again to the 1997 Award Winners!

JIM FINGER, Regional Ambulance Service, *EMS Officer of the Year*

TARA PACY, EMS District #3, Shelburne & UVM Rescue, *EMS Trainer of the Year*

MAJ EISENGER, MD, FAHC, EMS District #3, *Emergency Physician of the Year*

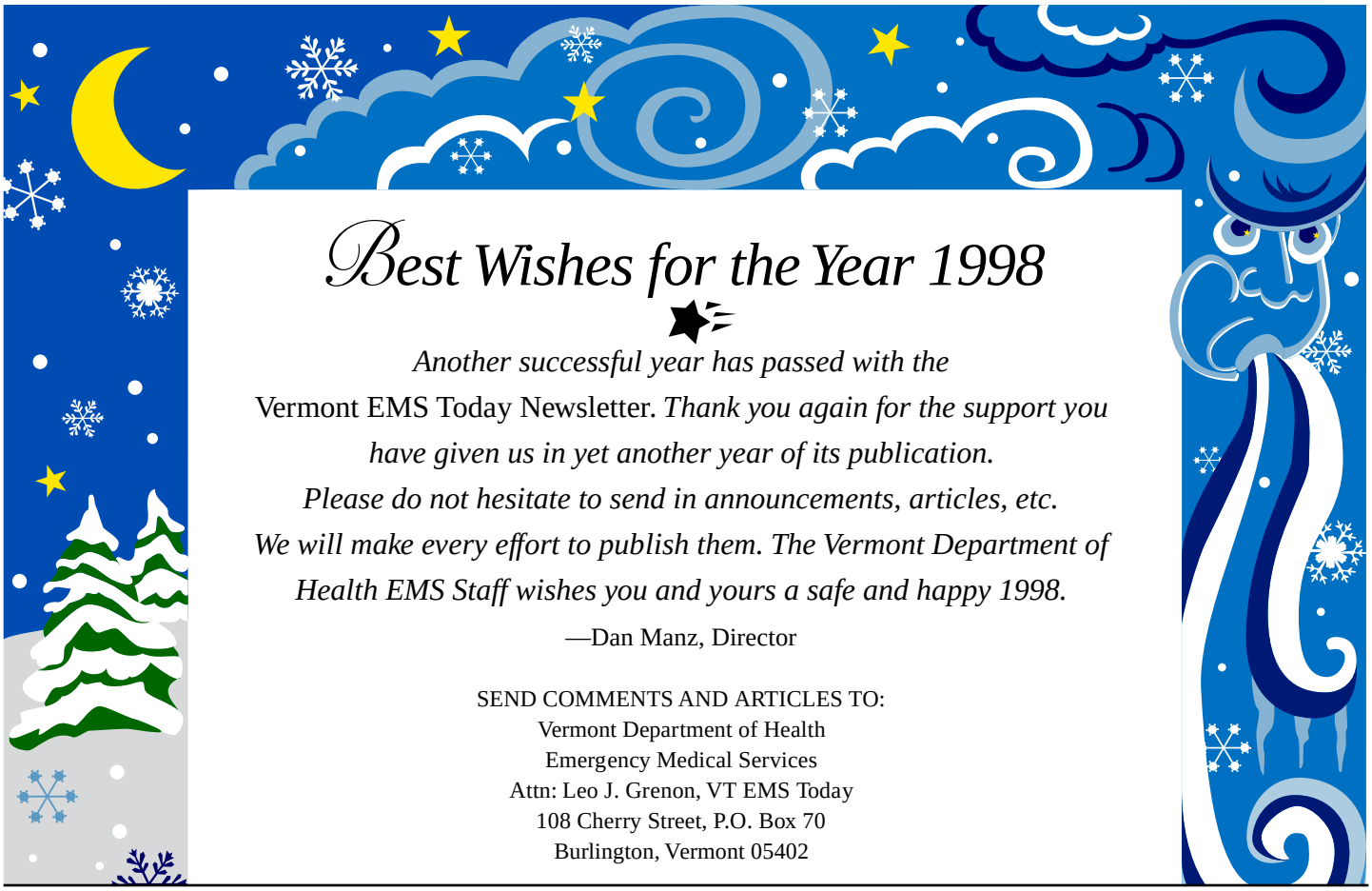
KATHY KARG, RN, FAHC, EMS District #3, *Emergency Nurse of the Year*

GEORGE BROWN, MD, *Vermont SAFEKIDS Injury Prevention Award*

CYNTHIA GATES, EMT-D, Franklin Rescue, EMS District #1, *EMS Advanced Rescuer of the Year*

MIKE PARADIS, EMT-I, Newport Ambulance Service, EMS District #2, *EMS Service of the Year*

MARY GRISWOLD, EMT-B, Shelburne Rescue, EMS District #3, *EMS Basic Rescuer of the Year*



Best Wishes for the Year 1998

Another successful year has passed with the Vermont EMS Today Newsletter. *Thank you again for the support you have given us in yet another year of its publication. Please do not hesitate to send in announcements, articles, etc. We will make every effort to publish them. The Vermont Department of Health EMS Staff wishes you and yours a safe and happy 1998.*

—Dan Manz, Director

SEND COMMENTS AND ARTICLES TO:
Vermont Department of Health
Emergency Medical Services
Attn: Leo J. Grenon, VT EMS Today
108 Cherry Street, P.O. Box 70
Burlington, Vermont 05402

File Update

Have you moved or changed your phone number or name since the last time you certified or recertified? Let us know se we can keep our records up-to-date.

Change of name and address form:

OLD INFORMATION:

Name _____

Address _____

_____ Zip _____

Phone _____

Certification number _____

NEW INFORMATION:

Name _____

Address _____

_____ Zip _____

Phone _____

Send to: Vermont Dept. of Health, Division of Health Protection
EMS & Injury Prevention
P.O. Box 70, 108 Cherry Street
Burlington, VT 05402

Vermont Emergency Medical Services

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